Family Care

A Pilot Program for

Redesigned Long-Term Care

Progress Update
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Department of Health and Family Services
Office of Strategic Finance
Center for Delivery Systems Development

What is Family Care?

Why change the long-term care services system?

Currently, a person who is eligible for publicly funded long-term care services can:

- Move into a nursing facility when he or she chooses;
- Seek admission into a local COP program to receive a package of community-based long-term care services, but in most cases cannot immediately be served by those programs; or
- Rely on individually arranged services funded by Medicaid or by counties to get by.

Some individuals obtain the cost-effective care they need and want, but in many cases, money is spent unwisely, the most appropriate services are not provided, and the individuals face health problems and functional limitations that might have been avoided.

How does Family Care change long-term care services?

Family Care provides for:

- A single entry point (resource center) to enable easy access and informed choices among programs;
- Enrollment without delay in a care management organization (CMO), upon determination of eligibility, to enable prompt initiation of intervention and cost-effective service packages;
- A comprehensive, flexible benefit package that includes both community services and residential long-term care, to enable the creation of individualized, cost-effective service plans;
- Interdisciplinary care management teams that include both nurses and social workers, to enable comprehensive assessments of individuals' needs, lower-cost primary care, and assured attention to preventive health care;
- A capitated payment rate, based on individuals' functional levels; to encourage cost-effectiveness and an emphasis on maintaining health and functional status;
- A host of innovative tools and opportunities to enable local agencies to plan and provide high-quality, cost-effective long-term care, including:
    - a web-based long-term care functional screen, which will enable local agencies to perform consistent, reliable determinations of individuals' long-term care needs;
    - a start-to-finish focus on member outcomes, so that each care management team is aware of, and supportive of, the results that each consumer seeks from his or her long-term care; and
    - state-of-the-art care planning tools, such as prevention guidelines that assist care management teams to ensure thorough attention to health maintenance; the 'Resource Allocation Decisionmaking" method (RAD) tool, a framework for identifying the most cost-effective services alternatives in cooperation with the consumer; and guidelines to ensure thorough consideration of all options before residential placement.

For more information, visit www.dhfs.state.wi.us/LTCare, the Family Care website.

Access to the Family Care Program

Are individuals of all target groups being screened?

Individuals who are actively seeking long-term care and exploring their options receive functional screens from Family Care resource centers. Not all who are screened are eligible—either financially or functionally—for long-term care under Medicaid.

Table 1
Initial Long Term Care Functional Screens Completed, by Target Group
October through December 2001

	Elderly	Developmental Disabilities	Physical Disabilities	Total
Counties with CMOs				
Fond du Lac	77	17	25	119
La Crosse	71	17	57	145
Milwaukee	1,015	3	7	1,025
Portage	52	6	19	77
Richland	26	5	9	40
Counties without CMOs				
Jackson	1	0	3	4
Kenosha Aging & PD	51	0	29	80
Kenosha DD	1	6	1	8
Marathon	51	2	8	61
Trempealeau	18	1	2	21
Total	1,363	57	160	1,580

Are individuals from all target groups enrolling?

The Family Care CMOs began enrolling members at different times: Fond du Lac in February 2000, La Crosse and Portage in April 2000, Milwaukee (which serves only the elderly target group) in July 2000, and Richland in January 2001. Each resource center and CMO first enrolled those individuals who were participating in the existing COP and waiver programs, then those who had requested community care in their counties, and then, individuals who were seeking long-term care for the first time. The resource centers recently began efforts to inform individuals in residential long-term care about the availability of Family Care.

Table 2
Total CMO Enrollment by Target Group
December 31, 2001

	Developmental Disabilities	Elderly	Physical Disabilities	Members
Fond du Lac	37.2%	50.6%	12.2%	765
La Crosse	31.9	41.1	27.0	1,008
Portage	35.6	46.9	17.6	484
Richland	35.1	48.5	16.3	203
Subtotal	**34.5%**	**45.8%**	**19.7%**	**2,460**
Milwaukee	0.0	100.0	0.0	2,240
Total	**18.4%**	**71.0%**	**10.6%**	**4,700**

This approach to enrollment affected the target-group composition of Family Care membership. At first, it looked very much like the waiver programs that were being replaced. The composition changed as individuals who had been seeking community long-term care enrolled, the majority of whom outside Milwaukee County were individuals with developmental disabilities. As efforts to offer Family Care to residents of nursing facilities result in additional enrollments, and as Family Care enrollment reaches a steady state, the proportion of elderly members is expected to increase.

What diagnoses do Family Care members have?

Table 3
The 15 Most Common Diagnoses Among Family Care Members
December 2001

	Number	Percentage
Hypertension (high blood pressure)	2,096	45.5%
Arthritis	2,006	43.5%
Diabetes mellitus	1,092	23.7%
Mental retardation	973	21.1%
Disorders of digestive system	963	20.9%
Depression	948	20.6%
Asthma, chronic obstructive pulmonary disease, emphysema, or chronic bronchitis	843	18.3%
Sensory disorders other than visual impairment or deafness	806	17.5%
Angina, coronary artery disease, myocardial infarction	769	16.7%
Osteoporosis and other bone diseases	736	16.0%
Congestive heart failure	656	14.2%
Hypo/hyperthyroidism	581	12.6%
Cerebral vascular accident (stroke)	573	12.4%
Joint disorders other than arthritis; fractures other than hip	540	11.7%
Allergies	514	11.2%

Note: Diagnoses are those noted on the most recent functional screens prior to January 1, 2001 for the 4,608 individuals who were CMO members on December 31, 2000 and who had a functional screen available in the Department's MEDS database.

What health-related services do Family Care members need?

Table 4
The 15 Most Common Health-related Services Needed by CMO Members
December 31, 2001

	Number	Percentage
Medication management* weekly or less often	1,497	32.5%
Nursing assessment weekly or less often	1,283	27.8%
Medication administration (not IV) 1-2 times per day	1,248	27.1%
Medication management* 1-2 times per day	938	20.4%
Medication administration (not IV) 3-4 times per day	658	14.3%
Medication management* 3-4 times per day	469	10.2%
Interventions related to behavior symptoms weekly or less often	425	9.2%
Medication administration (not IV) weekly or less often	395	8.6%
Exercises/range of motion 1-2 times per day	263	5.7%
Pain management weekly or less often	258	5.6%
Exercises/range of motion 2-6 days per week	217	4.7%
Medication management* 2-6 days per week	204	4.4%
Nursing assessment 2-6 days per week	201	4.4%
Nursing assessment 1-2 times per day	175	3.8%
Pain management 1-2 times per day	152	3.3%

* Medication set up, monitoring, or blood levels

How soon can people enroll?

Family Care is designed as an entitlement program, into which individuals seeking long-term care can enroll without waiting. Three of the five Family Care pilots are now able to enroll everyone seeking community long-term care at the time they request it, Milwaukee County CMO will reach this milestone by July 2002, and Richland County by January 1, 2003.

The Department is monitoring the ease and timeliness of the eligibility and enrollment process. In each CMO county, four entities work together to ensure that the enrollment process is timely and not overwhelming for potential enrollees. The resource center determines a person's functional eligibility and, in most counties, the resource center worker who did the functional screen "shepherds" the person through the remainder of the enrollment process, making sure all agencies receive the necessary information and that the referral to the CMO goes smoothly. The local economic support unit determines the person's financial eligibility, and then an independent enrollment consultant talks with the potential member to satisfy federal and state requirements that someone independent of the county that operates the CMO ensures that potential enrollees make informed choices. Finally, the economic support worker enters the enrollment date on state data systems, which generates the capitation payment to the CMO.

Access to Services in Family Care

Where are Family Care members residing?

Reflecting Family Care's initial enrollment strategies of having first enrolled individuals in community-based waiver programs and then those who had been seeking community long-term care, the large majority of Family Care members currently reside in the community. If recently initiated efforts to inform individuals in residential care about the availability of Family Care result in new enrollments, the numbers of Family Care members in nursing facilities will increase during 2002. Then, as care managers work with these individuals to arrange the long-term care services that most cost-effectively meet their needs, the numbers in nursing facilities should again decline.

Because initial enrollment efforts were, of necessity, extended to individuals not currently in residential care, Family Care CMOs have as yet had little experience or opportunity to relocate many individuals from institutional care. However, as Tables 6 and 7 show, individuals with more than one year in Family Care as of December 2001 were more likely to be living in the arrangements that they prefer than were new members. Among individuals who had been Family Care members for less than one year on December 31, 2001 (Table 6), 17.6 percent had indicated, upon enrollment, that they preferred to live in a different place than they were currently residing. Among those Family Care members who had been enrolled for more than one year on December 31 (Table 7), however, only 9.6 percent preferred to live elsewhere.

Table 6
Current and preferred living arrangements at the time of enrollment among Newer Family Care members in December 2001

Current Living Arrangement			Prefer to live elsewhere		Prefer to stay	
	Number	Percentage	Number	Percentage	Number	Percentage
Private residence	948	72.1 %	123	13.0 %	825	87.0 %
Group residence	283	21.5 %	36	12.7 %	247	87.3 %
Nursing facility	57	4.3%	53	93.0 %	4	7.0 %
Other	26	2.0 %	19	73.1 %	7	26.9%
Total	1,314	100.0 %	231	17.6 %	1,083	82.4 %

Table 7
Current and preferred living arrangements after one year among Members enrolled for more than one year by December 2001

Current Living Arrangement			Prefer to live elsewhere		Prefer to stay	
	Number	Percentage	Number	Percentage	Number	Percentage
Private residence	1,488	72.9 %	90	6.0 %	1,398	94.0 %
Group residence	479	23.5 %	64	13.4 %	415	86.6 %
Nursing facility	53	2.6 %	31	58.5 %	22	41.5 %
Other	20	1.0 %	10	50.0 %	10	50.0 %
Total	2,040	100.0 %	195	9.6 %	1,845	90.4%

Are Family Care members appropriately immunized?

The Family Care benefit does not include immunization or other primary health care services. However, because care managers are to monitor members' health status, the level of immunization among Family Care members is one indicator of how well the CMOs are doing their job. Individuals in Family Care target groups are recommended to receive influenza vaccinations once at the beginning of each annual flu season, and pneumonia vaccinations once every ten years. Because vaccinations are not advisable for some and because others can be expected to refuse vaccinations, the federal 'Healthy People 2010' initiative recommends vaccination rates among individuals older than 64 to be 90 percent; among non-institutionalized high-risk adults, the recommended target rate is 60 percent.

Although vaccination rates reported by CMOs in early 2002 were higher than baseline figures provided by the US Department of Health and Human Services, the achieved vaccination rates were lower. Because this is the first time that the CMOs have collected and reported these data, it is possible that the lowest rates may be a result of inadequate reporting. However, it is clear that CMOs could improve vaccination rates, or recording and reporting of vaccinations, or both.

Table 8
Influenza and Pneumonia Vaccination Rates Among Family Care Members
December 2001

	Influenza Vaccination Rate	Pneumonia Vaccination Rate
Fond du Lac	61.6%	32.7%
La Crosse	66.8%	50.6%
Milwaukee	78.0%	59.5%
Portage	21.7%	9.1%
Richland	52.4%	15.4%
Family Care Total	67.1%	49.8%
Healthy People 2010 (1998 baseline)	64.0 %	46.0 %
Healthy People 2010 (target for elders)	90.0 %	90.0 %

Other Issues in Family Care Services

- Each member has support from an **interdisciplinary care management team** that consists of a social worker and a registered nurse, with other professionals as needed. In the traditional waiver programs, nurses were not typically employed as care managers. In Family Care, the nurses' involvement enable assessments that reflect health needs and care plans that identify preventive measures necessary for high-risk conditions. The nurse care managers can also perform ongoing health monitoring in the course of routine care management, and provide the members with strong on-going linkages with physicians and other health care providers.

  Early indications are that expenditures for Family Care members' primary and acute medical care, which are not covered by the CMO, are lower than might have been expected in the absence of Family Care. Expenditures for primary care such as drugs and dental care are slightly higher, while total expenditures and expenditures for acute medical care such as inpatient hospital stays and emergency room treatment, are lower. This indicates that the CMOs—perhaps as a result of involving nurses in care planning--are having an effect in keeping members healthier than they might otherwise have been.

- CMOs are developing and using new **practice guidelines for the prevention of health problems most associated with functional decline**. Results of these efforts will not be known for a year or two, but CMOs are engaged in concerted projects to document baseline incidence of certain health problems among their members; to implement specific practice guidelines regarding identification and intervention in high-risk conditions; and to assess the extent to which these practices were successful. For example, the Fond du Lac CMO is engaged in a project to ensure that its members between the ages of 50 and 65 appropriately avail themselves of the most critical health screening tests, including Pap tests; mammograms; sigmoidoscopies; colonoscopies; fecal occult blood tests; prostate specific antigen tests; and cholesterol screening. Other prevention and wellness initiatives involve prevention of health problems associated with diabetes and with depression.

Are members achieving their outcomes?

Family Care is all about results, and Family Care members define those results. All of us, with or without disabilities, have certain circumstances that we consider important to the quality of our lives. Family Care case managers work with Family Care members to identify what is important to each member and to find supports and services that help the member achieve those goals.

Saying that every member identifies his or her own outcomes is not to say that every member gets whatever services he or she requests: *services* are not *outcomes*. For example, a member may desire a certain amount of mobility in order to attend public events of particular interest to that member: the outcome would be attendance at those events. The care management team would work with the member to identify the most cost-effective service that would enable attendance.

Family Care has identified 14 member outcomes, such as "People have privacy," "People live where and with whom they choose," and "People are free from abuse and neglect." Care management teams work with each CMO member to identify the circumstances that would constitute achievement of this outcome, and care plans are to reflect the members' preferences.

Annually, a random sample of CMO members are selected for in-depth interviews to determine whether their personally-preferred outcomes are present in their lives and whether they are being supported in the achievement or maintenance of those outcomes. Results from the most recent round of these interviews are shown in Table 8. Additional information regarding these results and how they are used to plan and improve Family Care's result can be found on the Family Care website, www.dhfs.state.wi.us/LTCare.

Table 9
Family Care Members' Outcomes and Supports
Interviews conducted between May and November 2001

	Members with the outcome present	Members with support for the outcome
People have privacy.	88.2%	78.8%
People are free from abuse and neglect.	84.3%	61.4%
People are safe.	81.3%	69.1%
People choose their daily routine.	81.2%	80.1%
People have personal dignity and respect.	76.6%	74.7%
People are satisfied with services.	71.8%	79.4%
People are treated fairly.	70.9%	74.6%
People choose where and with whom they live.	67.2%	74.8%
People achieve their employment objectives.	65.8%	72.9%
People remain connected to informal support networks.	64.1%	75.9%
People participate in the life of the community.	60.7%	68.3%
People experience continuity and security.	53.1%	44.6%
People have the best possible health.	50.8%	66.7%
People choose their services.	50.4%	65.3%

Other indicators of results

As Family Care CMOs mature and accumulate more experience, the Department will calculate additional indicators of their results. Efforts are currently underway to obtain and use information from members' annual functional screens and from service records to routinely determine:

- Are the functional levels of Family Care members being improved or maintained adequately, considering their age and disabilities?
- Are Family Care members experiencing an acceptably low rate of admissions to emergency rooms for preventable emergencies?
- Are Family Care members experiencing an acceptably low rate of hospitalizations for preventable illnesses and injuries?
- Are Family Care members achieving their objectives relating to employment?

Costs of Family Care

What are the capitated rates, and how are they calculated?

In Family Care, CMOs purchase services from local providers or provide care with their own staff. The Department pays each CMO a monthly rate for each member served by the CMO. For each member, the capitated rate paid to the CMO is unlikely to be the same as the amount paid by the CMO to the individual's service providers.

To support financial solvency of the CMOs while ensuring efficient care, Family Care rates are based on sound research on long-term care utilization and expenditures. A single, program-wide rate-setting methodology is used to calculate rates reflecting each CMO's clientele.

Table 10
Final 2001 Monthly Capitated Rates

	Comprehensive Eligibility Level	Intermediate Eligibility Level
Fond du Lac	$ 1,844.30	$628.79
La Crosse	$ 1,709.12	$628.79
Milwaukee	$ 1,721.77	$628.79
Portage	$ 2,516.51	$628.79
Richland	$ 1,910.15	$628.79

The primary element in calculating the capitated rate has been the cost of the enrolled individuals' care in the past. Enrollees' cost histories are obtained from state data banks and compiled for each CMO, along with assumed costs for new enrollees, which have been shown to be lower than those for individuals who have been receiving care for longer periods. Upward adjustments are made to these compiled costs for inflation, expected aggregate declines in health status, and administrative costs; downward adjustments are made to take into account the economies that can be achieved by managed care.

Beginning with the 2002 rates, the Department is calculating capitated rates based on the enrollees' level of functional needs, as cost histories and functional screens provide data to support such analysis.

Is there evidence yet that cost-effectiveness is improving?

To ensure that a waiver program such as Family Care does not provide care at a higher cost than existing programs, the federal Medicaid program requires the comparison of the new program's payments to the costs that would likely have been incurred had the same group of people received services under the existing system.

During calendar year 2000, approximately 2,325 individuals were enrolled as Family Care members. For each of these individuals, the Department paid the CMOs an average of $1,731 each month for their long-term care while they were enrolled. Average monthly costs for this same group of individuals with the same level of needs would have been $1,884 per month had they been served in existing fee-for-service long-term care programs—county COP and community-based waiver programs, nursing homes, and other residential facilities. This indicates that the CMOs were already, in their first year, providing services at a lower per-person cost to the Medicaid program than the existing programs. Due to the time it takes for CMOs to achieve the economies that Family Care makes possible, and additional months for billing and cost data to be compiled and analyzed, we are not yet able to determine the potential cost-effectiveness of Family Care.

Table 11
Average Family Care Capitation Payments compared to Monthly Costs for a Comparable Population in Fee-for-service Programs

	Average monthly Family Care payment	Monthly cost of fee-for-service care
Fond du Lac	$1,651	$1,920
La Crosse	$1,583	$1,817
Milwaukee	$1,466	$1,494
Portage	$2,395	$2,397
Program-wide	$1,731	$1,884

Notes: Average capitation rates in Table 11 differ from those reported in Table 10 due to different mixes of eligibility levels among the CMOs.